The woman may mean pain afterwards and this often arises from the back.

The clinical test is simple. After the pelvic examination the woman draws her knees up on to her chest and then the doctor gently presses the knees downwards even further. In the classical case the woman can say immediately that that is the pain of which she complains. Sometimes she may notice the pain a few hours later. Further examination of the back should be made with the patient prone by pressing firmly along the lumbar spine and putting it passively into full extension by lifting her thighs off the couch and pressing again. With the patient on her side passive rotation of the lumbar spine can be tested in both directions. The object is to try to reproduce the pain whether it be vague abdominal pain and tenderness or dyspareunia. If the pain is brought on by one of these manoeuvres treatment can be directed to the back, often with highly satisfactory results.

The history of postural back pain is one of alternating periods of relief and exacerbation. Neither exercise nor rest fully relieve the pain. At the beginning of each of these there is some relief, but this does not last. The obvious example is going to bed, which brings relief (negated if there is sexual intercourse), but getting up in the morning is also a relief since the pain has returned even with prolonged rest. If gynaecologists and general practitioners would routinely ask about backache and do the appropriate simple tests in women with pelvic symptoms they could help a larger number of patients than they do. More importantly, overanxiety about pelvic symptoms may be prevented when their true cause in the back is demonstrated.

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Children's coughs related to parental smoking

SIR,—Dr Anne Charlton emphasises the association between parental smoking and cough in children aged 8-19 years and assumes that passive smoking is the explanation (2 June, p 1647). An alternative mechanism may be the influence of smoking in pregnancy. Maternal smoking is known to predispose infants to respiratory illness but studies to date have not distinguished between the effect of passive smoking and that of smoking during pregnancy.[1-3] Respiratory infections in infancy have an adverse effect on lung function in later childhood and the increased incidence of cough in Dr Charlton's subjects may be due to the effects of maternal smoking on the fetus.[4,5] The finding of a greater influence of maternal than paternal smoking on respiratory symptoms supports this argument, whereas the finding of a higher incidence of cough in children with two parents smoking than in children with one parent smoking does not.

Probably both mechanisms are involved but their relative importance is yet to be shown. This should be borne in mind when making any inferences from Dr Charlton's paper. Evidence for the harmful effects of passive smoking is accumulating, but the mechanism whereby cigarettes cause respiratory symptoms in non-smoking children and infants has not been fully established.

K D FOOTE

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Medicines at school

SIR,—Some parents of children with chronic asthma or cystic fibrosis have pointed out to me that some school authorities confiscate medicines which the children, on doctors' instructions, have to take during school time. I have made inquiries at seven junior schools picked at random and can confirm the parents' stories. The heads (four out of seven) have acted without any reference to the child's doctor, the school clinical officer, or the parents. The reasons given were haphazard—protecting the normal children from Spinhalers, publicity about glue sniffing, Spinhaler over use, "a child on antibiotics should not be in the school in any case," and so on.

I have been reassured that all medicines were available in the heads' offices for the children to take on request. In practice such arrangements were unsatisfactory. One boy was "afraid to go and ask," a girl "forgot to ask," and another boy "could not find the head's office." In one case a direct request by a parent, a clinical officer, and a paediatrician that a child with moderate exercise induced asthma should be allowed to carry a Spinhaler was ignored.

A child with a chronic disease requiring regular treatment should have it unmolested even at school. It might be beneficial to set up a detailed inquiry into the prevalence of such practices in the United Kingdom so as to make general recommendations which would satisfy parents, their children, teachers, and doctors.

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Kielland's forceps delivery

SIR,—I am pleased that Dr Conor Carr (2 June, p 1694) intends to carry out a retrospective survey on maternal morbidity after Kielland's forceps delivery but I would like to take issue with him on a few points. Firstly, he found my description emotive. I had tried to make it factual and to defuse this emotionally charged issue by making a case for the midforceps controversy to be subjected to clinical trial and scientific assessment.

Secondly, while epidural or spinal block is essential for good analgesia, I am not sure that its use would reduce neurological complications. It could be argued that abolishing pain might lead to even greater damage being inflicted. A recent report with some similarities to mine (failed rotation and occipitoposterior delivery with Kielland's forceps) showed postnatal paraparesis in spite of, or perhaps even because of, epidural analgesia.[1]

The main error in Kielland's forceps delivery with poor outcome is the human compulsion to complete a procedure once undertaken. While Kielland's forceps are still widely used and until poor risk prognostic factors are defined I can only ask obstetricians to consider the words of Professor John Huddleston "There will be times when even the most experienced obstetrician will anticipate an easy midforceps operation but encounter difficulty in application, rotation, or traction instead. Critical to our ability to retain midforceps as a reasonable and acceptable method of effecting vaginal delivery is that in such cases the forceps attempt should be promptly abandoned and abdominal delivery effected. There is simply no justification in such a setting for persistently attempting vaginal delivery."[2]

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Analgesia in acute pancreatitis

SIR,—We agree with Mr S L Blamey and others (19 May, p 1494) that "potential addiction to narcotics in young adults presenting with recurrent episodes of pancreatitis, often secondary to alcohol abuse, is a cause for concern among clinicians treating this disease." We must take issue, however, with the comment that "buprenorphine appears to have little potential for physical dependence."

We have a patient with a history of addiction to alcohol and dipipanone for whom the latter drug was replaced with buprenorphine. The end result of a harrowing story is that he is now firmly addicted to buprenorphine and our attempts to wean him off it have so far been unsuccessful. Part of the problem is that buprenorphine is not a controlled drug and various bodies, including the Committee on Safety of Medicines, have been interested but powerless to take action. The manufacturers of buprenorphine (Temgesic) have indicated to us that they recognise the possibility of addiction, particularly in those who have a history of opiate abuse. Apparently there is some overlap of use of the pain receptors by both these drugs and cases of addiction have been documented. Our experience of this case has taught us to be very respectful of the possible risk of habituation to buprenorphine.

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Acute scrotal pain

SIR,—Dr Hilary King and Mr Peter Whelan emphasise the need for urgent exploration of the scrotum in young men who present with acute scrotal pain (26 May, p 1576). Intermittent scrotal pain, which may be due to repeated attacks of torsion of the testis, is infrequently documented but can result in testicular atrophy even without the testis undergoing acute torsion.[1] We recently reported a series of 26 patients presenting over four years with torsion of the testis in which 12 had the intermittent variety.[2] All symptoms in patients in the latter category cleared after fixation of the testes. Failure to recognise this condition may be because its presentation is not so